(3) The information was provided in a manner that was reasonably designed to effect informed agreement and met the requirements of paragraphs (g) and (h) of this section.

(g) *Enrollment information.* Enrollment information was provided by one of the following methods or a similar method:

(1) Presentation of an enrollment card or other document attesting to enrollment.

(2) Notice of enrollment from HCFA, a Medicare intermediary or carrier, or the M+C organization itself.

(h) *Information on payment terms and conditions.* Information on payment terms and conditions was made available through either of the following methods:

(1) The M+C organization used postal service, electronic mail, FAX, or telephone to communicate the information to one of the following:

(i) The provider.

(ii) The employer or billing agent of the provider.

(iii) A partnership of which the provider is a member.

(iv) Any party to which the provider makes assignment or reassigns benefits.

(2) The M+C organization has in effect a procedure under which—

(i) Any provider furnishing services to an enrollee in an M+C private fee-for-service plan, and who has not previously entered into a contract or agreement to furnish services under the plan, can receive instructions on how to request the payment information;

(ii) The organization responds to the request before the entity furnishes the service; and

(iii) The information the organization provides includes the following:

(A) Billing procedures.

(B) The amount the organization will pay towards the service.

(C) The amount the provider is permitted to collect from the enrollee.

(D) The information described in § 422.202(a)(1).

(3) Announcements in newspapers, journals, or magazines or on radio or television are not considered communication of the terms and conditions of payment.

(i) *Provider credentialing requirements.* Contracts with providers must provide that, in order to be paid to provide services to plan enrollees, providers must meet the requirements specified in § 422.204(a)(1) and (a)(1)(iii).

[63 FR 35085, June 26, 1998, as amended at 65 FR 40325, June 29, 2000]

§ 422.220 Exclusion of services furnished under a private contract.

An M+C organization may not pay, directly or indirectly, on any basis, for services (other than emergency or urgently needed services as defined in § 422.2) furnished to a Medicare enrollee by a physician (as defined in section 1861(r)(1) of the Act) or other practitioner (as defined in section 1842(b)(18)(C) of the Act) who has filed with the Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts under section 1802(b) of the Act with the beneficiaries. An M+C organization must pay for emergency or urgently needed services furnished by a physician or practitioner who has not signed a private contract with the beneficiary.

Subpart F—Payments to Medicare+Choice Organizations

SOURCE: 63 FR 35090, June 26, 1998, unless otherwise noted.

§ 422.249 Terminology.

In this subpart—

(a) The terms ''per capita rate'' and ''capitation rate'' (see § 422.252) are used interchangeably; and

(b) In the term ''area-specific,'' ''area'' refers to any of the payment areas described in § 422.250(c).

§ 422.250 General provisions.

(a) *Monthly payments*—(1) *General rule.* Except as provided in paragraphs (a)(2) or (f) of this section, HCFA makes advance monthly payments equal to 1/12th of the annual M+C capitation rate for the payment area described in paragraph (c) of this section adjusted for such demographic risk factors as an individual's age, disability status, sex, institutional status, and other such factors as it determines to

be appropriate to ensure actuarial equivalence. Effective January 1, 2000, HCFA adjusts for health status as provided in § 422.256(c). When the new risk adjustment is implemented, 1/12th of the annual capitation rate for the payment area described in paragraph (c) of this section will be adjusted by the risk adjustment methodology under § 422.256(d).

(2) *Special rules*—(i) *Enrollees with end-stage renal disease.* (A) For enrollees determined to have end-stage renal disease (ESRD), HCFA establishes special rates that are determined under an actuarially equivalent approach to that used in establishing the rates under original Medicare.

(B) HCFA reduces the payment rate for each renal dialysis treatment by the same amount that the Secretary is authorized to reduce the amount of each composite rate payment for each treatment as set forth in section 1881(b)(7) of the Act. These funds are to be used to help pay for the ESRD network program in the same manner as similar reductions are used in original Medicare.

(ii) *MSA enrollees.* For MSA enrollees, HCFA makes advanced monthly payments as described in paragraph (a)(1) less the amount (if any) identified in § 422.262(c)(1)(ii) to be deposited in the M+C MSA. In addition, HCFA deposits in the M+C MSA the lump sum amounts (if any) determined in accordance with § 422.262(c).

(iii) *RFB plan enrollees.* For RFB plan enrollees, HCFA adjusts the capitation payments otherwise determined under this subpart to ensure that the payment level is appropriate for the actuarial characteristics and experience of these enrollees. Such adjustment can be made on an individual or organization basis.

(b) *Adjustment of payments to reflect number of Medicare enrollees*—(1) *General rule.* HCFA adjusts payments retroactively to take into account any difference between the actual number of Medicare enrollees and the number on which it based an advance monthly payment.

(2) *Special rules for certain enrollees.* (i) Subject to paragraph (b)(2)(ii) of this section, HCFA may make adjustments, for a period (not to exceed 90 days) that begins when a beneficiary elects a group health plan (as defined in § 411.101 of this chapter) offered by an M+C organization, and ends when the beneficiary is enrolled in an M+C plan offered by the M+C organization.

(ii) HCFA does not make an adjustment unless the beneficiary certifies that, at the time of enrollment under the M+C plan, he or she received from the organization the disclosure statement specified in § 422.111.

(c) *Payment areas*—(1) *General rule.* Except as provided in paragraph (e) of this section, the M+C payment area is a county or an equivalent geographic area specified by HCFA.

(2) *Special rule for ESRD enrollees.* For ESRD enrollees, the M+C payment area is a State or other geographic area specified by HCFA.

(d) *Terminology.* As used in paragraph (e) of this section, ''metropolitan statistical area,'' ''consolidated metropolitan statistical area,'' and ''primary metropolitan statistical area'' mean any areas so designated by the Secretary of Commerce.

(e) *Geographic adjustment of payment areas.* For contract years beginning after 1999—

(1) *State request.* A State's chief executive may request, no later than February 1 of any year, a geographic adjustment of the State's payment areas for the following calendar year. The chief executive may request any of the following adjustments to the payment area specified in paragraph (c)(1) of this section:

(i) A single Statewide M+C payment area.

(ii) A metropolitan-based system in which all nonmetropolitan areas within the State constitute a single payment area and any of the following constitutes a separate M+C payment area:

(A) All portions of each single metropolitan statistical area within the State.

(B) All portions of each primary metropolitan statistical area within each consolidated metropolitan statistical area within the State.

(iii) A consolidation of noncontiguous counties.

(2) *HCFA response.* In response to the request, HCFA makes the payment adjustment requested by the chief executive.

(3) *Budget neutrality adjustment for geographically adjusted payment areas.* If HCFA adjusts a State's payment areas in accordance with paragraph (e)(2) of this section, HCFA at that time, and each year thereafter, adjusts the capitation rates so that the aggregate Medicare payments do not exceed the aggregate Medicare payments that would have been made to all the State's payments areas, absent the geographic adjustment.

(f) *Determination and applicability of payment rates.* (1) All payment rates are annual rates, determined and promulgated no later than March 1st, for the following calendar year.

(2) For purposes of paragraphs (b) and (c) of §422.252, except as provided in §422.254(e)(4), the ''capitation payment rate for 1997'' is the rate determined under section 1876(a)(1)(c) of the Act.

(g) *Bonus payments.* (1) HCFA provides bonus payments to the M+C organization(s) that first offers a plan in a previously unserved county on or after January 1, 2000 and no later than December 31, 2001. The bonus payment amounts equal—

(i) For the first 12 months after a plan is offered in a previously unserved county, 5 percent of the monthly capitation rate otherwise payable under this section; and

(ii) For the subsequent 12 months, 3 percent of the monthly capitation rate otherwise payable under this section.

(2) A previously unserved county is defined as—

(i) A county in which no M+C plan has been offered; or

(ii) A county in which an M+C plan or plans has been offered, but where any M+C organization offering an M+C plan notified HCFA by October 13, 1999, that it will no longer offer plans in the county as of January 1, 2000.

(3) A plan is considered to be offered when—

(i) The M+C organization sponsoring the plan has a contract in effect to serve beneficiaries in the previously unserved area; and

(ii) The M+C plan is open for enrollment.

[63 FR 35090, June 26, 1998; 63 FR 52613, Oct. 1, 1998, as amended at 65 FR 40325, June 29, 2000]

§ 422.252 Annual capitation rates.

Subject to the adjustments specified in this subpart, the annual capitation rate for a particular payment area is equal to the largest of the following:

(a) *Blended capitation rate.* The blended capitation rate is the sum of—

(1) The area-specific percentage (specified in §422.254(a)) for the year multiplied by the annual area-specific capitation rate for the payment area as determined under §422.254(e) for the year, and

(2) The national percentage (specified in §422.254(a)) for the year multiplied by the national input-price-adjusted capitation rate for the payment area as determined under §422.254(g) for the year.

(3) Multiplied by the budget neutrality adjustment factor determined under §422.254(d).

(b) *Minimum amount rate.* (1) For 1998—

(i) For the 50 States and the District of Columbia, the minimum amount rate is 12 times $367.

(ii) For all other jurisdictions the minimum amount rate is the lesser of the rate described in (b)(1)(i) or 150 percent of the capitation payment rate for 1997.

(2) For each succeeding year, the minimum amount rate is the minimum amount rate for the preceding year, increased by the national per capita growth percentage (specified in §422.254(b)) for the year.

(c) *Minimum percentage increase rate.* (1) For 1998, the minimum percentage increase rate is 102 percent of the annual capitation rate for 1997.

(2) For each succeeding year, the minimum percentage increase rate is 102 percent of the annual capitation rate for the preceding year.

§ 422.254 Calculation and adjustment factors.

The following are the factors used in calculating the per capita payment rates: